

OREGON HEALTH SCIENCES UNIVERSITY HISTORY PROGRAM

ORAL HISTORY PROJECT

INTERVIEW

WITH

*Harold D. Paxton, M.D.*

Interview conducted June 30, 2004

by

Richard Mullins, M.D., and Matthew Simek

## SUMMARY

In this interview, OHSU Professor Emeritus Harold D. Paxton, M.D., discusses his fifty-year career in neurosurgery, sharing anecdotes about memorable surgeons and describing changes in neurosurgical practice from the 1940s through the 1990s.

The interview begins with a discussion of Dr. Paxton's medical school years at Johns Hopkins, where he observed the first "blue baby" operation, performed by Dr. Alfred Blalock. After residencies at the Albany Medical Center in New York and military service during the Korean War, Dr. Paxton obtained further neurosurgical training under Dr. Henry Schwartz at Washington University in St. Louis. Paxton relates anecdotes about Schwartz and other neurosurgeons of the day.

Dr. Paxton came to Oregon in 1956 to work with Dr. John Raaf in the University of Oregon Medical School's Division of Neurosurgery. Paxton talks about Raaf, about the neurosurgical service at the university, and about the neurosurgical residency programs both at the University and at Good Samaritan Hospital. He shares his recollections of memorable characters at UPMS and discusses the university administration. He talks at length about the development of a university practice plan in the 1970s.

Dr. Paxton spent two sabbatical years away from Oregon, the first in Kenya at Kenyatta National Hospital, and the second in Germany at the Landstuhl Regional Medical Center. He describes his experiences in setting up the first neurosurgical training program in Kenya, and notes that sabbaticals are a good opportunity for physicians to stop and assess their careers.

In commenting on changes he has seen over his half-century in medicine, Dr. Paxton addresses the tension between medicine and law and discusses the evolution of the physician-patient relationship. Finally, he comments on what he sees as the future of medicine, noting that the looming shortage of physicians and the rise of specialization may lead to the demise of the solo practitioner.

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Interview with Harold D. Paxton, M.D.  
Interviewed by Richard Mullins, M.D.  
June 30, 2004  
Site: BICC  
Begin Tape 1, Side 1

MULLINS: Good morning. Today is June 30, 2004, and we're in the BICC, the Bio Information Communication Center here at Oregon Health and Science University. It's 9:30 in the morning, and I'm Richard J. Mullins, from the Department of Surgery, and I'm interviewing Dr. Harold Denver Paxton.

Let me begin by asking you about where you were born and where you were raised.

PAXTON: Well, I was born in Clay, West Virginia, and I grew up from the age of about two in Widen, West Virginia. Clay at one time was the poorest county in the USA; twenty-seven percent on welfare.

MULLINS: What was your family's background?

PAXTON: Well, they've been there forever. The Paxtons had come over from Rockford in Virginia. They had come out in the 1700s and 1600s from England. Actually, it was during the reign of James I, when James I was a Protestant and tried to run all of the lowland Scotsmen over to suppress the Irish. James II was a Catholic, and he suggested that the Irish kill all those people, and so they came to the USA [laughs].

MULLINS: Your father was in the railroad business?

PAXTON: My father was a conductor on a branch of the B&O Railroad.

MULLINS: Were you the first medical doctor in your family?

PAXTON: I was the first one in my family to go to college.

MULLINS: How is it that you ended up at the very prestigious Princeton University?

PAXTON: Just lucky, I guess. I actually went to—we had a good little school in this town I was in. It was run by a disciple of Dewey. The school went from one to twelve. Dewey who was the guy at Columbia University that had a theory about how you teach reading and writing to kids. At that time it was during the Depression, and the county could not afford the schools, so the coal mine paid all the teachers, and they paid them more than they paid the rest of the state. And the classes were very small.

MULLINS: So it was small. And you went through high school at your hometown there in West Virginia?

PAXTON: Yes.

MULLINS: Then, did you apply to Princeton?

PAXTON: No.

MULLINS: Did you take a test, or something, to get in there?

PAXTON: I went to Princeton with the V-12 program, the Navy program.

MULLINS: Tell me about that, please.

PAXTON: About the program?

MULLINS: Yes. Maybe we could start with how you got in the Navy.

PAXTON: Well, I got drafted.

MULLINS: In 1942?

PAXTON: Forty-three. They came and got me, to make a long story short [laughter]. I went through the recruitment station with eighteen hundred people, and I picked the Navy. I had been drafted, of course, in March, and then they—I was making an effort to get into the Naval Air Force, but then I decided I wouldn't like that, that looked dangerous to me, and so I took an examination—which I didn't know what it meant, and the next thing I know—and they sent me to Princeton University. And the V-12 program was probably the most successful education program this country has ever had.

MULLINS: So what year did you start at Princeton?

PAXTON: Forty-three.

MULLINS: And did you actually spend some time on a ship in the North Atlantic?

PAXTON: No, I don't think so. I was on a ship out there, but I never heard a shot fired in anger, I think.

MULLINS: When were you out there? What year?

PAXTON: That would have been in '43.

MULLINS: What was it like in the North Atlantic?

PAXTON: Rough [laughs] and cold.

MULLINS: For a guy from West Virginia, it wasn't your idea of—[laughs]. So anyways, Princeton was a better opportunity.

PAXTON: I loved Princeton University. I think it's the best educational institution in the world. It was very difficult, because most of the other students had gone to Hale or Choate or Exeter and I hadn't done any of that, so I had to work harder than the rest of them, but I caught up.

MULLINS: And when did you graduate, then, or complete your education at Princeton?

PAXTON: I left there in September of '44.

MULLINS: And where did you go in September of '44?

PAXTON: I went to Johns Hopkins.

MULLINS: So this was an accelerated educational program brought on by the Second World War?

PAXTON: During the war, the Second World War, you had three semesters a year, and you had a week in between each semester. It's a wonderful system.

MULLINS: So you basically took the premed courses at Princeton?

PAXTON: No. Princeton had no real premedical course. You had to pick up the courses you needed to get into medical school. It was designed by Woodrow Wilson like Oxford: the first year was all set, you had to take what they gave you, and the second year you worked on your major.

MULLINS: Okay. And then tell me about your experience of going to Johns Hopkins. That was to go to the medical school?

PAXTON: Yes.

MULLINS: Tell me about your experience. Did the Navy decide that too?

PAXTON: No—well, yes and no. I applied and got in, and they made me cancel my appointments and then they turned around and shipped me down there.

MULLINS: So it was a bit confusing at the time.

PAXTON: Well, they wanted us to apply, they suggested we apply; and then they decided, by God, we're going to handle it all ourselves.

MULLINS: I see. So in any case, you started at Hopkins in 1944.

PAXTON: September of '44.

MULLINS: So you had spent a year at Princeton?

PAXTON: I spent three semesters and a half of another one.

MULLINS: Okay. And then you started at Johns Hopkins. What was Hopkins like in 1944 as a medical school?

PAXTON: Well, Hopkins has always had a very good faculty, but the buildings were old and decrepit. A lot of the stock that they had used to finance the school was in the Baltimore and Ohio Railroad, which went bankrupt in 19—so it had its loose ends. The buildings were dark, and they were sometimes cleaned and not cleaned too well; and they simply were broke. But I think every medical school was broke; if not now, they certainly were during the Depression.

MULLINS: And this is, of course, near the end of the Second World War. What are your recollections of the Second World War?

PAXTON: I was there [laughs].

MULLINS: Did you feel threatened by it? Was it a time that you weren't sure what was going to happen?

PAXTON: Oh, yes. I expected to get shot, but I never did. But once I got in medical school and went along, they had—let's see, two years or a year before I graduated, the school took a six-month sabbatical. Then we went back and we graduated.

MULLINS: There were some legendary surgeons, of course, at Hopkins. I guess we should start with the professor of surgery, Dr. Blalock. What's your recollection of Dr. Blalock?

PAXTON: Well, now, Dr. Blalock was a very affable guy, very amicable, and he had—he was meek, but when he had an opinion, he could shove it across real well. He was a researcher, and he did his research in the Hunterian Laboratory. He was always that, but as he got along, and once he became famous for his little baby operation, he also became a big politician. He was president of all the general surgical societies. In general, it was said, during the late '40s, that the whole of American surgery was run by about five surgeons, and he was one of them.

MULLINS: I've read that he taught the medical students in a clinic on Friday.

PAXTON: Yes.

MULLINS: Can you tell us about that?

PAXTON: Well, he gave—at that time, many of our lectures, if not most of them, were given by the professor—that was the tradition at Johns Hopkins. And he had this clinic, and he'd bring in a patient and use it as an example of the disease and how you handle it. We'd sit around, and he would discuss it and tell us. Every now and then we'd tell him he was wrong, and it didn't seem to bother him very much.

MULLINS: How many students were in the class?

PAXTON: In my class? Seventy-six.

MULLINS: So he would interact in a very professional—

PAXTON: Oh, very personal manner.

MULLINS: With the medical students.

PAXTON: Yes.

MULLINS: Did that encourage you, in the sense of becoming a surgeon? Why did you decide to become a surgeon?

PAXTON: I don't know. I always—once I got in medical school, I thought I'd be. Mark Ravitch was one of the people that I played in the [Pavotomy?] show, which is kind of a show that we had around here when we called the professors some four-letter words and told them, perhaps a little brusquely, what we thought of them. And I liked the surgeons.

MULLINS: Well, another surgeon whose father was from the railroad industry was Walter Dandy.

PAXTON: Yes.

MULLINS: Can you tell me about your experiences with Professor Walter Dandy?

PAXTON: Well, I knew the Dandy family well, because Walter and I are in the same class.

MULLINS: Walter Junior, his son.

PAXTON: Son, both at Princeton and at—and I knew him at Princeton and Johns Hopkins, and he was, of course—well, he was in my club. We had eating clubs. So I met the family, and I met Dr. Dandy very early.

Now, I got interested in neurosurgery because of Dr. Dandy, and he used to—we had classes on Saturday, and Dr. Dandy would make his son come and watch him operate. Well,

I'd go along. I didn't have much trouble in anatomy, and, besides, they had a very good-looking scrub nurse, and I was quite interested in her—but to no avail, I want to add [laughs].

MULLINS: Well, how did Dr. Dandy treat you? Did he encourage you?

PAXTON: No, he didn't. Dandy didn't really like medical students. He liked the residents. He was a very methodical man, and every case was documented and numbered. Very original, a very good technical surgeon. Operations were his business.

MULLINS: And he was skilled at it?

PAXTON: He was very skilled at it.

MULLINS: I know that Dr. Cushing made a big to-do about doing neurologic evaluations of the patients to precisely locate the tumor. Did Dr. Dandy do the same sort of meticulous examination?

PAXTON: If he did, he did it very fast, but he was a superb diagnostician. We used to have—the neuro-ophthalmologist, Frank Walsh, and Frank Ford, the neurologist, would have a conference once a week, and they would get two hundred people, and those guys were almost always right. It was amazing.

MULLINS: So just to emphasize, in this modern era of CAT scans, that if a patient came in with a neuro complaint and they were going to operate on their brain tumor, they had to use physical examination to decide where to put the flap, is that correct?

PAXTON: [Laughing] That's exactly right.

MULLINS: What happens if you made a mistake?

PAXTON: Well, you'd have to back out. You know, I saw a bunch of the operative records Dr. Cushing had, and on about every third one he wrote, "As usual, Gilbert Horrax put the flap in the wrong place" [laughs].

MULLINS: So you were at, as a medical student—I think you also observed one of the blue baby operations.

PAXTON: I saw the first three of them.

MULLINS: Can you tell us your recollections of Dr. Blalock's first Blalock-Taussig shunt?

PAXTON: Well, Dr. Blalock was a fairly rough surgeon. He hadn't had a lot of surgical training. And he was always complaining; he kind of whined and whined, "Why won't somebody give me a scissors that will cut?" And he was assisted by Dr. Longmire and

the resident anesthesiologist, Merel [Harmel]—because Austin Lamont was the chief, and the child was in such lousy condition, he refused to give him anesthesia.

MULLINS: This is the first blue baby?

PAXTON: The first one. But it went just fine. And he had Vivien Thomas there, and that's how we got to the operation. We used to hang around the Hunterian Laboratory, and one of my friends was working with him, and I used to help him once in a while.

MULLINS: So Vivien Thomas was the Afro-American technician who worked in Dr. Blalock's laboratory.

PAXTON: Yes. And he was a slick technician.

MULLINS: He did some of the early subclavian artery to pulmonary vein shunts—no, pulmonary artery shunts in dogs and actually kind of perfected the technique. It's an amazing thing to think that they were able to do, in a small baby that has the most—what kind of suture did they use?

PAXTON: I don't know, but they had vascular sutures. I didn't know what...

MULLINS: Was it [switch down?] or was it—do you know?

PAXTON: I don't know. I didn't look that closely. As a medical student you don't really look for that sort of thing.

MULLINS: You were up in, like, the gallery?

PAXTON: Yep, up in the gallery.

MULLINS: Where was Mr. Thomas during this operation?

PAXTON: He was standing down by the operating room table, looking over the anesthesiologist's shoulder. And Helen Taussig, who was in child cardiology, was in the room. So away they went, and it worked just like cap busters.

MULLINS: And did they intubate the baby?

PAXTON: No. You didn't intubate people in those days. They used an open-faced mask and an oral pharyngeal airway.

MULLINS: Amazing. So here's this child who—how big was the child?

PAXTON: [Demonstrates] About like that.

MULLINS: Blue, of course.

PAXTON: Yes.

MULLINS: You've got to lay them on their side, and they're blowing oxygen. Did they even have oxygen they could give the kid?

PAXTON: Oh, sure.

MULLINS: And some ether? Was it an ether—

PAXTON: I don't—I'm sure that—that's what they were using in those days. I'm sure it was ether.

MULLINS: So he opens the chest and he does this operation that's never been done before, and, of course, it turns out to be a brilliant success. What were your thoughts about it? Just kind of an interesting day at Hopkins?

PAXTON: Well, I didn't have much thought about it because I didn't know much about surgery. I knew that I was probably watching something that had some historic value, or would be historic, and so I just watched. I was fascinated by operative procedures anyway.

MULLINS: What year did you graduate from Hopkins?

PAXTON: June 1948.

MULLINS: And so what did the Navy think of you at that point? Were you out of the Navy?

PAXTON: We were out of the Navy.

MULLINS: So where did you go after that, to Albany, New York?

PAXTON: I went to Albany.

MULLINS: And what did you do there?

PAXTON: I did two years of general surgery and a year of neurology.

MULLINS: And you were interested right from the start, Dr. Paxton, in neurosurgery?

PAXTON: Yes.

MULLINS: So you were targeting that?

PAXTON: Yes.

MULLINS: Well, we know that you end up with one of the most prestigious training residencies in St. Louis. How did you accomplish that?

PAXTON: Well, that was—that was really something. I wrote a letter to Henry Schwartz saying, “Dear Dr. Schwartz, I’m interested in neurosurgery. Could you please send me the forms and whatever documents you need from me to apply to your residency?” And I got a little short note back saying, “Dear Dr. Paxton, you are appointed assistant resident in neurosurgery,” signed Henry Schwartz [laughter]. And that was all. I didn’t hear from him. This was in September, and I was stuck in Europe and I couldn’t come for an interview, and I—and so I wrote a letter to him and I said, “Please give me instructions about what you want to do when I get there.” I got a short note back saying, “Dear Dr. Paxton, Report to Griff Harsh,” signed Henry Schwartz [laughter].

MULLINS: Okay. So you’re in Albany for two years in general surgery, and then you do a year of neurology where you perfect your diagnostic skills.

PAXTON: Yes.

MULLINS: And then how did you end up in Europe?

PAXTON: Well, I didn’t have twenty-four months of active duty, so-called, and I got caught in the doctor draft.

MULLINS: For the Korean War?

PAXTON: Yes.

MULLINS: So that was ‘48-49, ‘49-50, ‘51.

PAXTON: Fifty-one to ‘53.

MULLINS: You’re in Europe. What are you doing in Europe?

PAXTON: I was a medical officer for the Western European division of the CIA.

MULLINS: Okay. Are you at any liberty to briefly discuss your experiences as a doctor for the Central Intelligence Agency in the early Cold War?

PAXTON: Well, we were—I remember at that time they expected the Russians to attack us at any time. The CIA had recruited a whole new division, which they called the Office of Policy Control, which were essentially to train guerilla warfare fighters, people that they were going to drop into various areas. And so they needed some doctors along with them. So I happened to know—one of the graduates of Albany was the chief of medicine for the CIA, and he talked me into doing my Army duty there. That was great. I enjoyed that; I

had a good time. Unfortunately, if the war had started, I'd have sure been killed fooling around with guerilla fighters.

MULLINS: You were in what part of Germany?

PAXTON: I was in Heidelberg.

MULLINS: Did they actually send agents across the Iron Curtain?

PAXTON: Oh, yes. All the time.

MULLINS: People you knew?

PAXTON: No. That was another division, the covert division, the Office of Strategic Operations.

MULLINS: And your job, as a doctor, was to do what? Just keep the supply in surgeons?

PAXTON: Yes. I had two other doctors that worked for me, and we had to get the supply problem, we had to get—these people, you couldn't just run them into a hospital and out of a hospital because the Russians would know exactly who they were, and they probably did. We had several operations set up that were—the Russians knew exactly what we were doing.

MULLINS: Were you married at the time?

PAXTON: No. I got married in 1955.

MULLINS: So you were a single guy in Europe. What's your recollection of Germany at the time?

PAXTON: Well, Germany was just—they still had not rebuilt anything, and they had just had their currency reform in 1948, and they were just coming around. Up till there, they were consuming seventeen hundred calories per day. That's about half of what they consume now.

MULLINS: So it was a harsh time still.

PAXTON: For the Germans it was, yes.

MULLINS: And for you, was that a good two years?

PAXTON: Oh, yes.

MULLINS: Why is that?

PAXTON: I just had a good time, that was all.

MULLINS: You had worked pretty hard in medical school.

PAXTON: And I had to put in my Army duty, and that was a lot better than being in Korea.

MULLINS: Okay. So you're in Germany and you send a letter to the famous Dr. Schwartz and he sends you back the acceptance.

PAXTON: Yes.

MULLINS: So when did you leave Germany and present yourself to St. Louis?

PAXTON: I left Germany on the twentieth of June in 1953, and I appeared in St. Louis on the thirtieth of June.

MULLINS: And you started a residency in neurosurgery that lasted how many years?

PAXTON: Three years.

MULLINS: Tell me about working for Dr. Schwartz. Or maybe we should start—who was Dr. Schwartz and who trained him?

PAXTON: Well, he and I happened to go to the same college and medical school, and he had done a year of, I think, neuropathology in Breslau. He was a very bright fellow. And he had been a fellow and trained at Washington University in St. Louis and had actually joined Ernie Sachs and Leonard Furlow and was in practice until he went off to the Army and Furlow went off to the Navy and Ernie Sachs stayed there.

MULLINS: So Schwartz was trained in St. Louis by Dr. Sachs, who had been trained by Dr. Dandy or Dr. Cushing or—?

PAXTON: Oh, no. He had very little training. He had gone and had I think a year, or less, perhaps, than that, in—this was in, I think, Vienna, but one of the places. He was the first professor of neurosurgery in the world. He was appointed in 1910.

MULLINS: Before Cushing?

PAXTON: Oh, yes.

MULLINS: So Sachs has established a school of training in St. Louis.

PAXTON: Yes.

MULLINS: And Dr. Schwartz was trained there.

PAXTON: Yes.

MULLINS: In the '30s, we're talking about?

PAXTON: Yes.

MULLINS: And when you arrived, he was the professor of surgery. And three years—tell us about those three years of training with Dr. Schwartz.

PAXTON: Well, it was very hard. We had only two or three men for the whole service, and it was very hard service. We worked—rounds started at fifteen till six in the morning, and you ostensibly got every other night off after you worked up your patients, as many as we can get out of the hospital, till about ten o'clock. And that was easy for the first two years because I wasn't married. But then I got married, and there was some tight squeeze, some understanding.

Dr. Schwartz was a very good operator. He was a very hard man.

MULLINS: I know we've talked about at Hopkins there was this issue of, if you were the chief resident you were never sure whether you were going to finish or not until Blalock decided you were done. Did they have the same thing in St. Louis?

PAXTON: No. In my particular point of view, I think it was even worse. What they had in St. Louis is that you would come up to be chief resident—and not in neurosurgery—and they would have twelve or fourteen assistant residents, and they would pick three of them or two of them, and all the rest of them were going to leave.

MULLINS: So you could have spent two years in pre-training before—were you doing neurosurgery all the three years?

PAXTON: Yes.

MULLINS: And you may not have made the cut. The famous pyramid—infamous pyramid thing.

PAXTON: Yes. They had the pyramid system on everything.

MULLINS: So you made the cut and you were one of the two chief residents.

PAXTON: Well, I was the only one. We only had one chief resident—

MULLINS: In neurosurgery?

PAXTON: But they had two in general surgery.

MULLINS: So how was it as the only chief resident? Was it even the worst of the three years?

PAXTON: Well, you were on twenty-four hours a day and 365 days out of the year, and it was a very busy service. You helped Dr. Schwartz do his cases, and you did the— Washington University Barnes Hospital would allow seventeen percent no-pay patients, and they were mine.

MULLINS: You had a clinic that you would see these at?

PAXTON: Yes.

MULLINS: What would be, say, a representative crosscut of the cases you would have done as a chief resident?

PAXTON: Well, that was the day when we were doing a lot of prefrontal lobotomies and we were doing scalenus anticus sections; and we were doing sympathectomies, because Smith decided that his operation cured hypertension, which it certainly did not. We didn't have much trauma. We had a lot of brain tumors, and a lot of trigeminal neuralgia.

MULLINS: Spine work?

PAXTON: Yes. We did disk, cervical disk.

MULLINS: Meningioma, was that, like, a chief resident case?

PAXTON: Oh, yeah. Well, on your ward, your seventeen percent of the patients, they were *all* yours. In all of my time as chief resident, Henry Schwartz came in and helped me once. Otherwise, you were strictly on your own.

MULLINS: And when you left, did he shake your hand and wish you good luck?

PAXTON: Yes.

MULLINS: And did he consider you, then, one of his protégés and one of his—in the sense that you had been trained by him and he expected you to go into an academic career?

PAXTON: Yes, he did that.

MULLINS: Did he tell you that?

PAXTON: No, he just said, “Good-bye and be careful,” and “You’re going in with a fellow that I’ve known longer than I knew you.”

MULLINS: And that was?

PAXTON: John Raaf.

MULLINS: Dr. Raaf. So when did you decide to move to Portland?

PAXTON: Well, I always wanted to come to the Northwest in the first place. I don't know why. As a kid I suppose I was reading Zane Grey novels—you know, the higher fiction that I always aspired to.

John Raaf came through—and I interviewed for a job down in San Francisco, and my wife didn't want that because she'd have to live in downtown San Francisco. She made no bones about it; we were going to have children. Then I had one—I could have gotten one in Kansas City. Actually, there were six of them around. The weather in St. Louis convinced me that I didn't want to live in the Midwest.

I went to White Plains, New York, where my wife grew up, or Scarsdale more specifically, and I applied to the White Plains Hospital. And I went in and talked to them, and they said, “Oh, yes, we'll be glad to have you; come on in. But you have to refer all of your cases to our neurosurgeons and assist them for the first two years.” And I thought, well, you know, I really don't want to get this close to my in-laws anyway, so I'm off [laughter].

MULLINS: So you had negotiated with Raaf. What kind of an arrangement with Dr. Raaf?

PAXTON: Well, he offered me a salary for—he paid me ten thousand dollars a year, which, to me, was one heck of a lot of money, and I think it was.

MULLINS: So let's step back here and talk a little bit about John Raaf. He was trained at the Mayo Clinic.

PAXTON: Yep. He loved the Mayo Clinic.

MULLINS: As a neurosurgeon?

PAXTON: Yes.

MULLINS: And he moved to Oregon in—?

PAXTON: In 1936.

MULLINS: And then he was one of the few neurosurgeons in Portland?

PAXTON: Well, the first neurosurgeon in Portland was Arthur McLean, and Arthur had trained with Cushing; and I actually saw a personalized book of Percival Bailey and Cushing's on meningioma in which Cushing had written in it, “Arthur, you are the best man

that I ever trained.” But he was a little obsessive-compulsive, and it took him six or eight hours to do a physical examination, and then when he operated on the patients at County Hospital, he insisted on sleeping in the room overnight. And it got just a little bit difficult, so they went and got John, and John was the second. Then Dr. McLean committed suicide, I think in 1940.

MULLINS: Dr. Raaf, then, was hired by the University of Oregon?

PAXTON: No, he was not hired by the University of Oregon. He came out to join the Portland Clinic, but Tom Joyce, who was the head of Surgery here, said, “Being the only one in this area in this specialty, you’d better be out on your own,” so he did. But he was always very fond of the Portland Clinic.

MULLINS: Dr. Joyce worked for the Portland Clinic, but he was the chief of Surgery—

PAXTON: Oh, yes.

MULLINS: But he also had the appointment of chief of Surgery here at the University.

PAXTON: And Dr. Selling was chief of Medicine here, and Guy Strohm was chief of Urology, and Dr. Dillehunt, who was the Dean, was an orthopedist in the Portland Clinic.

MULLINS: So these were the faculty, but they also worked at the Portland Clinic.

PAXTON: That’s right. And Dr. Baird was an internist with the Portland Clinic, and W.K. Livingston, who was the first full-time professor of Surgery, was a surgeon at the Portland Clinic. The Portland Clinic ran the Medical School during that period.

MULLINS: And you know Dr. Joyce, I think, had a myocardial infarction and died in, like, forty—

PAXTON: Seven, I think.

MULLINS: Forty-seven, okay. He was followed by Dr. Livingston—

PAXTON: That’s right, W.K. Livingston.

MULLINS: Who basically moved up to the Hill here and had an office?

PAXTON: Yeah.

MULLINS: At that time, 1947, there was the Multnomah County Hospital and there was the children’s hospital, which was Dillehunt Hall. Those were the two places where patients were cared for.

PAXTON: Yes.

MULLINS: At the time, Dr. Raaf was the chief of Neurosurgery.

PAXTON: Yes. We did the neurosurgery, he did, and after I came here I did...

MULLINS: So you joined him in 195—

PAXTON: Six.

MULLINS: Six, as a fully-trained neurosurgeon, and you worked up here and you worked where else?

PAXTON: Good Sam. Well, I did a lot of things. I worked at—I did most of the surgery up here after I got here because John was too busy; he had a big practice. Then in '58, I started doing the spinal surgery for the Barnes Veterans Hospital across the river; and otherwise I was at Good Sam.

MULLINS: So you thought—I'm just trying to get this clear. When you came here in '57, you thought of yourself as working for the University of Oregon?

PAXTON: Yes.

MULLINS: Under the supervision of John Raaf, who had this kind of mixed appointment. He was up here, but he also had a lot of private patients downtown.

PAXTON: Oh, he had a lot of them; a big practice.

MULLINS: Tell us a little bit about what it was like to practice up here at Multnomah County Hospital. Did you have a clinic?

PAXTON: Well, I started the clinic after I got here because I wanted to see what happened to the patients that I operated on, because otherwise Bill Krippaehne looked after the head injuries, and they were seen—and Bill had been helping with it. He was fairly interested and was knowledgeable about it. But I—and then we got the clinic, and it got pretty big pretty fast, because then they started sending consultations into the clinic. But I made it.

MULLINS: Multnomah County, what kind of patients would be at Multnomah County say compared to at Good Samaritan?

PAXTON: Multnomah County had the most decrepit group of patients I've ever seen. Emphysema, old age, cardiac failure, you name it. Old, the poor, the halt, the sick. It was a splendid hospital. We had very little to work with, but the residents ran it and were supervised by the volunteers from downtown. And I was amazed, when I got here from

Washington University, how many people they got out of that hospital that I don't think we could have gotten out of Washington University.

MULLINS: And you were doing a neurosurgical practice up here. What kind of patients were you operating on?

PAXTON: Well, we saw a lot of chronic subdural hematomas in the alcoholics, and I was doing a lot of thalamotomies for Parkinsonism—I started up here in doing that.

[End of Tape 1, Side 1/Begin Tape 1, Side 2]

PAXTON: I started up here in doing that, and whatever general [administration?] we had. But we had a difficult time. For instance, the first case I did was an epidural hematoma in the middle of the night, and we get in—and, by the way, they had—Alice Scharf was the nurse that ran the operating rooms, and she was superb. Anyway, I get all the instruments up here, and we've got the nurse, who was a medical student, and—I forget who was helping me, if anybody. So I said to the instrument nurse, "Hand me your rongeur." He said, "I don't know what that is. This is the first time I've ever scrubbed." He said, "I'm a medical student." So I said, "Well, I'll pick it up, and you just put it back in the same place. That's all we have to do" [laughter].

MULLINS: And who were you operating with? Was it a general surgery resident?

PAXTON: Whoever you could lay hands on. Often, I would bring the resident—one of the residents at Good Sam would come up and help me.

MULLINS: The Good Sam resident was being trained in neurosurgery by Dr. Raaf?

PAXTON: Then—they were residents of the University of Oregon. As a matter of fact—well, that was one of the problems. When we got the new professor of Neurosurgery, John Raaf was on the Board of Neurological Surgeons. He just went to the Board and got his residency approved at Good Samaritan Hospital, and then the residents elected to stay at Good Sam, so they didn't have any residency up here for a year, year and a half.

MULLINS: So you're working up here, and—who was Dr. Austin?

PAXTON: Well, George was the full-time professor of Neurosurgery. He came out from the University of Pennsylvania, trained by Dr. Grant at the hospital of the University of Pennsylvania.

MULLINS: And he started here what year, do you remember?

PAXTON: I think—I would say about '59, but I'm not all that certain.

MULLINS: You were sort of a junior faculty and he was hired as the chief?

PAXTON: Yes.

MULLINS: And replaced Raaf?

PAXTON: And replaced Raaf. They offered the job to Dr. Raaf, although they would never make him more than acting before because there was considerable animosity between him and Dr. Livingston, which had existed since Raaf came in 1936. So they offered him the job, but they didn't pay him enough; he didn't take the job. That was one of the reasons. The second reason was that he had trained at the Mayo Clinic, and at the Mayo Clinic neurologists worked up all these patients for the neurosurgical service, and he had a series of neurologists who worked up patients for him. He didn't work up patients, he just walked in and gave an opinion, and so forth. And, of course, the School didn't have that kind of money, they weren't going to hire those neurologists or pay them, and so he was not going to be able to bring his crew. And we had twelve employees, we had a big office, and he would have had none of that. So he decided to stay at Good Sam.

MULLINS: Well, Dr. Paxton, this is an important time for the Medical School. It's following the Second World War, and in those years afterwards when it's a medical school where the faculty is predominantly working downtown; and there's a transition period up to 1960 when they were trying to hire full-time faculty.

PAXTON: When I got here, they were in the process of hiring a lot of full-time faculty.

MULLINS: Who was making that decision? Who was the driving force for changing the Medical School?

PAXTON: Well, Baird was the fellow who got the credit for it, and I think it's probably he that did it.

MULLINS: Do you think someone told him to do it, or they just got him—

PAXTON: No.

MULLINS: He was the Dean.

PAXTON: Yes. Well, this was common around the country. I mean, it wasn't just unique in this place. All the other schools were—there was a lot of money, and the schools were building up rapidly, and they could afford it.

MULLINS: Let's just take a moment to talk about the governance, if we could. It was the University of Oregon's medical school, meaning that the Board of Higher Education of the State of Oregon that oversaw the University, the whole University of Oregon, also had oversight authority over the Medical School.

PAXTON: Sure.

MULLINS: So the Dean would be answering to the President of the University of Oregon down in Eugene, I assume.

PAXTON: Actually, there was—as I understand it, there was really very little relationship between the University of Oregon. We were a school as part of it, but we were separately managed by the Board of Higher Education; and the University of Oregon gave the degrees to the graduate.

MULLINS: So when there were these political confrontations and disputes, who was the final judge and arbitrator of who won and who lost?

PAXTON: Well, for the—between the universities and Branford Millar—they would all go down and get their budget together. Branford Millar told me that Baird was one of the most difficult people he had to deal with, because he was trying to build Portland State, and he said Baird would come in with this sick child, and he would get all the money [laughs]. That's the way it went.

MULLINS: He was very effective, Dr. Baird, at dealing with the Legislature?

PAXTON: He was very effective.

MULLINS: And so the legislators said, "I'm going to support the Medical School."

PAXTON: Yep.

MULLINS: Now, let's talk about the building of this new South Hospital, we call it today, this University Hospital. What's your recollection of that? That happened when you arrived, is that right?

PAXTON: It opened about a year before, and the Doernbecher was moving into the top—which was the top two floors, fourteen and thirteen.

Well, the decision to make a hospital certainly was made during the Second World War, because the Legislature allotted a sum of money to build the hospital, and it wasn't big enough, and so Dr. Baird built the now Baird Hall Administrative, and it opened in 1948. Then they allotted another sum of money, and they started building the hospital.

MULLINS: And it was completed prior to your arrival?

PAXTON: Yes.

MULLINS: So you worked at both Multnomah County Hospital and did you do operations at the South Hospital?

PAXTON: Oh, sure.

MULLINS: What was the restriction regarding the type of patients you could accept at the South Hospital?

PAXTON: Well, politics rears its ugly head. There was a group of people in practice downtown, not always associated with the Medical School, who was fearful that if they admitted private patients, they would become the dominant figure in medicine in Oregon; and they were exactly right. They shouldn't have been surprised anyway, because, as I say, university medicine in its present status is built into the structure, the social structure, of the western hemisphere. So they got it fixed so that—in the charter, whatever they do it with—that they couldn't admit no-pay patients—or, it could be only no-pay patients.

MULLINS: So if you saw a patient who had finances and they needed a meningioma operation, you would admit them to what hospital?

PAXTON: St. Vincent's.

MULLINS: And you would operate on them there?

PAXTON: Yes.

MULLINS: This is, like, '58, '59?

PAXTON: Yes.

MULLINS: And if they had no insurance and they were sent to your clinic up here, you would operate on them here.

PAXTON: We would operate here, yes.

MULLINS: And you wouldn't bill anybody for anything you did here.

PAXTON: No. Now, we got around—they started to bill because they were running out of money. And Dave Baird told me when he left, he retired, that he wasn't—he didn't mind retiring because there was not going to be enough money. Well, it turns out he was wrong, too, at that.

Bill Zimmerman—and by that time, Charles Holman was the Dean—came around, and they figured that they could collect the private fees—if the patient was in University Hospital and they had health insurance, they could collect the private physician's fees, but not for room or drugs or that sort of thing. So we signed an agreement in about 1968 saying, "Well, yeah, go ahead; take the fees." I don't think they ever did much about it, at least not that I know of.

MULLINS: So were patients billed for having been in this hospital?

PAXTON: No.

MULLINS: So who paid for it?

PAXTON: The State did.

MULLINS: They got a chunk of money from the State to run University Hospital—

PAXTON: Yes.

MULLINS: And the Multnomah—did the County pay for Multnomah County?

PAXTON: The County paid for Multnomah County, and then Don Clark—and they were running out of money, too. And Don Clark announced that he was going to get some kind of a health benefit for the welfare workers and that they were going to dump the County Hospital, which they did over a five or seven year period by cutting their allotment to them a million dollars a year.

Then they sold it—and Dr. Holman told me this. They sold it to the Medical School for one dollar, and he said it was the worst buy he ever made [laughter].

MULLINS: And what was the worst—what was it about it that made it the worst? Just because there was such a burden financially?

PAXTON: Well, it needed a lot of work done, and it's—you know, earthquake improvement. It had been there, and nobody had done anything with this building, certainly not after 1929 when the crash occurred. Money was short, as it always is, and it sat empty for a long time, damn near empty.

MULLINS: So we have this perspective that the school is going through an evolution. You're hired as a junior faculty by Dr. Raaf, and then Dr. Austin is hired up here as the full-time professor of neurosurgery in the late '50s, and you're the assistant or associate professor. How did that work out?

PAXTON: Well, I didn't—it worked fine. I didn't have any problems with it. I started teaching neuroanatomy in 1958, and I kept running the clinic out here, so I was involved with the Medical School all the time.

MULLINS: And Dr. Austin, would he do cases?

PAXTON: He would.

MULLINS: And was a neurosurgeon. Now, when did you become the chief of Neurosurgery?

PAXTON: Nineteen sixty-seven.

MULLINS: What were the circumstances of that?

PAXTON: Well, there was a certain amount of dissatisfaction with Dr. Austin's performance. I really came in '66 to be head of the surgical section, general surgery, and that, of course, didn't make him very happy. And he was—as a lot of people are, he'd be gone for long periods. For instance, a couple of cases I helped the residents with, he was on call, but they couldn't find him. He was in San Diego or somewhere. So in general, there was a lot of unhappiness.

MULLINS: Now, at that time in the '60s there was the Department of General Surgery, and Dr. Krippaehne was the Chairman.

PAXTON: Yes.

MULLINS: And you were the—there was a division in the department, of neurosurgery, a Division of Neurosurgery.

PAXTON: Yes.

MULLINS: So the chain of command was the chief of Neurosurgery to Krippaehne, to Baird. Was it basically Dr. Krippaehne who appointed you the chief of Neurosurgery?

PAXTON: No, Baird did.

MULLINS: And was there a recruitment process? Did they have some other people come through, or did they just call you up one day and say...

PAXTON: Oh, they just called me up and said, "Would you be interested?" I was doing a lot of hypophysectomies for breast cancer and that sort of thing, and we were doing a lot of thalamotomies, about a hundred and so many of them a year.

MULLINS: And these are at Good Sam or were they up here?

PAXTON: And up here too, up here.

As a matter of fact, the single-cell work, when I came here—in the old number six operating room, they put screen wire around it to do single-cell work, and then, of course, the machines got good in the single-cell—practically before they had it up. Then they had two x-ray machines that were exactly across, and very powerful, to use for thalamotomies.

So I was always involved with the School.

MULLINS: And what was the thalamotomy going to accomplish when you did it?

PAXTON: Oh, it helps a lot of people who have Parkinsonism.

MULLINS: With the tremors?

PAXTON: Well, nowadays they say it works better for tremors. In my day, it worked much better for rigidity. But I made large lesions.

MULLINS: So you take the job of chief of Neurosurgery in '67. Could we just step back and talk about the General Surgery transition? Livingston was replaced by whom?

PAXTON: J. Englebert Dunphy.

MULLINS: What are your recollections of Professor Dunphy? He's another East Coast surgeon, there, Dr. Paxton.

PAXTON: Well, as he said, modern surgical academia was ruined by the jet airplane. He spent a lot of time on jet airplanes. And, of course, he was very ambitious, and he became the head of the American College of Surgeons and, I think, the American Board of Surgeons. He did a great deal of traveling. And I once asked him who was running the department, and he said Krippaehne, the same people that always run it. So I think Krippaehne was a great chairman.

MULLINS: I think, actually, Dr. Clare Peterson was the interim Chairman after Livingston. What were the circumstances of Dr. Livingston's leaving, do you recall?

PAXTON: He just retired. He got to retirement age, and he bought himself, I think, eighteen acres, or something, down on the Metolius, and he moved over to the Metolius River and died over there.

MULLINS: It's a wonderful place.

So Dr. Peterson is the Chair for a while; then Dunphy, the high-flying guy from the East Coast, if I can say that. Do you think he had a significant influence on this transition period?

PAXTON: No, I don't think he did. He was very politically minded. And they would not let him take patients out of the hospital, and he didn't like the salary arrangements, of course, that he would be getting. I don't think he was ever terribly happy here, but he certainly climbed in the political world.

MULLINS: As far as the development of the Medical School and their reputation in the nation, do you think things were changing in that time?

PAXTON: Oh, yes. I think he was a great help for that, because even when I came here they thought—at least at Washington University—that the University of Oregon Medical School was the end of the earth. That's the jumping off place.

MULLINS: What do you think Dr. Starr's famous research and operation had in terms of influence on the reputation of the School?

PAXTON: Oh, I think it advanced at least the cardiovascular surgeons. He was a great influence on it. He was one of the better-known open-heart surgeons, and one of the early ones, for that matter. No, there's no question Albert has had a worldwide reputation.

MULLINS: That must have been kind of an exciting time at the University of Oregon.

PAXTON: Yeah, it was.

MULLINS: And so you took over. What happened to the residency there? When did the neurosurgery residency move up—out of Good Sam and move up here?

PAXTON: It never did. We had two neurosurgical programs, one up here and one down at Good Sam.

MULLINS: Okay. When did the one start here? What year? Under Austin?

PAXTON: Yeah. About 1960. Then later on, John got up in his seventies, and in the private hospitals they usually stop you when you're doing surgery when you get in the seventies. And he wanted me to take over the program down there, and I didn't want to. The program we had here was busy enough, we had enough material, and the residents were very good. So then they had—there were five or six neurosurgeons down at Good Sam, and when John asked them to keep the residency going, they refused. They folded.

MULLINS: Okay. So you were the chief of Neurosurgery here. Did you have any problem finding neurosurgery residents?

PAXTON: We used to get a lot of residents—no, no trouble at all. In fact, I often—I usually tried to hire people that were interns or residents here because I figured they'd done service for us, I knew them and how they were going to be, and I didn't have to make any judgments, or I'd have no surprises. That's where we would—we had a lot of students—six percent of the class went into neurology, neurosurgery, or neurological in those days. Now it's down to about one percent or one-and-a-half.

MULLINS: Who was the chief of Neurology in those days?

PAXTON: Roy Swank.

MULLINS: Can you tell us a little bit about Dr. Swank and how he ran Neurology?

PAXTON: Well, Roy thought of himself as being a researcher. As a matter of fact, I used to be the attending three months out of the year on Neurology, on the basis of my one year. He was interested in multiple sclerosis and interested in research, and he saw

thousands of people who had multiple sclerosis, or something like it, and he sort of let the department run itself.

MULLINS: Did you see neurosurgery change a lot during your twenty-five years?

PAXTON: Oh, it's an entirely different business now.

MULLINS: How has it changed?

PAXTON: Well, the biggest change is the introduction of specialties, because the American Board of Neurological Surgery fought specialization and would not allow it. Now they're specialized as fellows and not as residents, so now they become specialized.

The other change is that now the practicing neurosurgeon no longer wanted to do intracranial stuff. They say it's not cost effective—which would not have suited me at all.

And the operations we did have all changed. In my day, when you had a brain tumor, one-third of it had to be done at night because they came in comatose. Now they have very few symptoms at all, and the diagnosis is made by MRI or a CAT scan. We used to do a lot of sympathectomies for hypertension, and the people would be hypotensive for about six weeks after and couldn't get out of bed, and then the hypertension would come back again. But we went along several years doing that.

MULLINS: When did you do your first carotid endarterectomy, Dr. Paxton?

PAXTON: In 1958. We took the operating room microscope and went over to the morgue and practiced over there, and that's how we started.

MULLINS: Were you doing angiograms preoperatively?

PAXTON: Yes. Originally, all of the cerebral angiograms were done by neurosurgeons.

MULLINS: And how would you do those?

PAXTON: A [Percocini?] stick in the neck. And we did them until Melvin Judkins came back here, and, of course, they had that big angio suite. He wouldn't let us use his equipment.

MULLINS: Who was that?

PAXTON: Mel Judkins.

MULLINS: Judkins. Was he before Dotter?

PAXTON: Oh, no. He was one of the people that Dotter sent over to Seraphina, whatever, the Karolinska Institute, to take a year in the—because their angiography was ahead of ours. And he came back—he liked to do hearts, and that sort of thing.

MULLINS: So you would do the angios, your own carotid stick angios.

PAXTON: Yes.

MULLINS: Tell me—I'd like to talk about your colleague Dr. Gallo. When did Dr. Gallo join you, and tell us a little bit about Dr. Gallo, please.

PAXTON: Well, let's see. When did Tony come? Tony came in about '70, '69 or '70. George Schemm was here before and was the second in the department, and I got along with George very well, but he left to become the head of neurosurgery at what was then the Woman's College of Pennsylvania. Then we got Tony, who I'd heard about, because up at Madigan—he was in the Army, and he was a very good teacher. So he came down, he was interested in the job; and I interviewed several people—I interviewed a lot of them, as a matter of fact, but I thought, well, I'll get along with him, so I hired him.

MULLINS: Now, he was trained as a neurosurgeon in the Army?

PAXTON: Yes, partly. Most of his training for neurosurgery occurred at the University of Pennsylvania.

MULLINS: He had done a tour of Vietnam?

PAXTON: Yes.

MULLINS: Is it true that they had a price on his head over there?

PAXTON: Yes.

MULLINS: How did that work out?

PAXTON: They didn't shoot him [laughter]. They gave him a big medal, you know, hanging down to here, the top deal. He was teaching neurosurgeons how to handle battle casualties.

MULLINS: So he joined you in '69-70.

PAXTON: Yes.

MULLINS: Did he have a particular area of interest?

PAXTON: Well, he was interested in pediatrics, and we made him the head of—because he had a year in pediatric surgery at the Pittsburgh Children's Hospital, so we made

him chief of Pediatric Surgery. But we had a problem about that sort of specialist, because we had the Veterans to do, we had the University Hospital to do, we were doing spinal surgery over in the Barnes Veterans. And pediatrics didn't pay all that well, so we subsidized him. And he and I would rotate, so all through—he would do Veterans three months, and then I would do the Veterans three months, then I would do the pediatrics while he was over with the Veterans.

MULLINS: So there were just the two of you for, what, twenty years?

PAXTON: Up until about 19—let's see. Up until about 1976.

MULLINS: You used to have some of the trainees stay for a year or so, didn't you?

PAXTON: Well, I did not like having the trainees—at Washington University you had to do a year of research, and I felt that about half the people who did that wasted a year because they weren't interested in it and they didn't do it. So I made it an elective year, and I had a deal with them that if they wanted to stay on in a research capacity, I would keep paying the resident salary.

MULLINS: So they would be kind of like the junior staff.

PAXTON: Yes.

MULLINS: Who were some of the people that did that?

PAXTON: Well, I don't think any of them ever eventually did it, but we hired Cal Tanabe and Rick Waller, and they were here until 1980.

MULLINS: Errett Hummel, was he another?

PAXTON: Errett Hummel was here before them, as a matter of fact.

MULLINS: You've trained a lot of very talented and successful neurosurgeons, it seems.

PAXTON: I'm pretty proud of them. I think they've been good citizens.

MULLINS: They're spread all over the country?

PAXTON: Mostly on the West Coast. I hate say it, but there are two in New York, one in Miami, so they're around all over. One in the Midwest.

MULLINS: Have you been on the Board of Neurosurgery?

PAXTON: No, I never was on the Board.

MULLINS: Did you get involved in sort of national politics with neurosurgery?

PAXTON: No, I didn't do that.

MULLINS: Can I ask why that is?

PAXTON: I didn't like it. I didn't particularly like medical meetings. I'm one of those people that when I went to a medical meeting, I didn't go out and politic; I sat down there and listened to what the people had to say. And you know, it required—now, I could have been a part of what they called the Washington University Mafia, because they really ran neurosurgery for twenty years.

MULLINS: Dr. Schwartz, he was editor of the *Journal*?

PAXTON: Editor. But his people were president of the Harvey Cushing and the Society and on the Board and all the other things. But that required a lot of traveling, and you had to have someone do your work for you.

MULLINS: Like Dr. Dunphy.

PAXTON: Like Dr. Dunphy. And I didn't have anybody—I didn't have the slack of letting me do that sort of thing. Besides, I never liked airplanes. I feel that the principle of flight has not been worked out [laughter].

MULLINS: Well, could I ask, as you evolved in terms of being a leader in neurosurgery here in Oregon, did you and Dr. Schwartz remain in communication?

PAXTON: Oh, yes.

MULLINS: How did that work out?

PAXTON: It worked out fine. He was a very, as I say, difficult, if not impossible, man in the operating room, but he was a charmer outside. And his son practiced neurosurgery here, and he would come out visiting him, and we'd go out to dinner, my wife and I. My wife loved him. She loved him because we had him out to dinner once, and she was having fondue, which she learned to make in Europe. Henry was sitting there with his bread, and the damn fondue dish collapsed onto the table, and Henry kept right on eating all the scraps, and I said to her, "We've got to keep this up. I've only got four dollars, and there's not a pork chop in the house" [laughs]. So she thought that was an absolutely charming thing, and I have to admit...

And his wife, Edie, was a lovely—she was a pediatrician. I remember one night we were scrubbing, and Henry was being unduly vocal, as he was a little apt to be, and we hear this voice saying, "That'll be enough out of you, Henry," and it's Edie up there. And Henry quieted right down [laughs].

MULLINS: Well, in retrospect, why do you think he was that way? Was he under a lot of pressure?

PAXTON: Yeah. Well, for one thing, he was overworked. They only had two people on the faculty, and they were doing seven hundred cases back in the day. That's one of the reasons the residents were so overworked, you know. We were there night and day. They didn't have a staff; a couple of years later, they had six people. But it was hard, and he was a driver.

MULLINS: But your style was a lot different, I think.

PAXTON: Oh, yes. I learned early. I didn't want that around. I think it actually interfered with efficiency, and I think it certainly interfered with the operative procedures.

MULLINS: And I think both you and Dr. Gallo—I was on his service a long time ago, and you were quite gentlemanly about it.

PAXTON: I thought we were.

MULLINS: And I think you delegated a lot of responsibility to the chief resident.

PAXTON: Well, I had a—the way my program worked was that it was a progressive program. The first year you learned how to do disks, subdural hematomas and some of the other things; second year you learned how to do the cervical things, you did biopsies, gliomas; and in the fourth year you learned how to do the tumors and—

MULLINS: The third year you were the chief at the VA.

PAXTON: The chief at the VA. That was a wonderful rotation.

MULLINS: You would help over there, and other folks would help at the VA.

PAXTON: We rotated it every three months. But the program over there then was integrated. We made all the residents on—and all the attending staff made rounds twice a week over at the Veterans, and they came from the Veterans and made rounds every day—well, three times a week at the University Hospital. And on Monday morning we'd start at 6:30, and they'd bring their films over for the operations, and we'd go over all the patients that were going to be operated on and make sure we didn't make the usual mistakes.

MULLINS: You lived through the era of the introduction of the CAT scan. Would you want to comment on how CAT scanners changed neurosurgery?

PAXTON: You no longer needed to do a neurological examination. We had an interesting deal on how we got one. We asked Charlie Dotter if he would buy one, and he said, "Absolutely not. It's like the ballistic cardiogram. It's never going to amount to anything." So we went to Holman and said, "Say, we're going to raise" —Chuck Gerber, who

was the neuroradiologist, and Tony Gallo and I, “we can raise \$750,000. You just give us a room, and we’ll give you one-third of the revenue.” When Charlie heard that, he went ballistic, and he appeared in the Dean’s office with the seven hundred thousand in hand [laughs].

MULLINS: So Dotter got the first CAT scanner.

PAXTON: Well, it wasn’t the first CAT scanner. Good Sam got the first CAT scanner in town. Dotter did not want to buy it. He thought it was going to amount to nothing.

MULLINS: But it was obvious to—because I can remember doing those carotid angiograms for dilating subdurals in comatose brain-injured patients in the middle of the night. That’s what we used to do.

I guess it eliminated the air ventriculograms?

PAXTON: Oh, that’s all gone away. Nobody knows how to do that.

MULLINS: You did a fair number of those, Dr. Paxton?

PAXTON: Well, when I went to Washington University, that was the only diagnostic test we were doing for the sides. And, you know, there are great disadvantages to it. You’ve got to take a puncture of the brain; it was sometimes hard to hit the ventricles if they had a tumor, and then it only showed you where the tumor—not what the tumor was, but that there was something pushing there. So every craniotomy was an exploration, and you had to know what you were looking at. That was kind of fun, in retrospect.

MULLINS: Well, I think we’ve been at this an hour. Can we take a break?

[End of Tape 1, Side 2/Begin Tape 2, Side 1]

MULLINS: I’d like to talk about the role of the President at Oregon Health and Science University as a leader. So I think we can begin with the first president, and that was Dr. Bluemle, and my notes say he started in 1974. Can you tell us about the role of the President?

PAXTON: Well, Bluemle came in and took everything over. He severely diminished what the Dean did. In fact, he moved Charles Holman out of his office into a much smaller office and fired Joe Adams. But he was the boss. And every President we’ve had, that was a fact that they didn’t step around one way or the other.

MULLINS: And the President was appointed by the President of the University of Oregon?

PAXTON: By the Board of Higher Education.

MULLINS: Was that part of a concerted effort to change the University of Oregon Medical School do you think?

PAXTON: Well, I think having the Dental School and the Medical School—and remember, Crippled Children’s was in this. Dick Sleeter ran that, but they had a separate budget. I don’t think that the Chancellor felt that he had any real control over it or a real feel for what was going on, so he wanted the President to get it all together.

MULLINS: And was this considered by some downtown in private practice a threat, that the University got more unified?

PAXTON: No, I don’t think the President was ever looked upon as a threat.

MULLINS: When did they decide to start taking paying patients at the University Hospital?

PAXTON: The practice plan started in about ‘74 or ‘75.

MULLINS: And that was the same time—

PAXTON: Actually, it started before Lew Bluemle. Did he get here—

MULLINS: My notes say that he came in ‘74.

PAXTON: All right, then, in ‘73.

Bob Stone was the Dean in those days, and he appointed myself—I was chairman of the first practice committee. And we worked on it for a while. It didn’t take very long. By that time, they—they had not approved putting private—but they did very shortly. Anyway, we concocted a plan that we thought was splendid and ideal, and the faculty turned it down absolutely cold.

MULLINS: What were some of the components of the plan?

PAXTON: Well, the one we had, we had a limit on income, indexed against the cost of living, and they didn’t like that, almost universally.

MULLINS: Who’s “they”?

PAXTON: The principal leader in opposition to it was Clare Peterson, and Ken Swan and Ken’s right-hand man, Christensen. Al Starr didn’t like it. The idea of limitation did not appeal to them.

MULLINS: So if I could try to understand this, the practice plan would enable the faculty to bill and collect money up to a point, and then after that point additional revenue would go to the Medical School.

PAXTON: That's right.

MULLINS: And that was your proposal, and that was rejected?

PAXTON: Yes.

MULLINS: By the other faculty?

PAXTON: Yes.

MULLINS: Okay. What happened next?

PAXTON: Well, then they appointed another committee, as always happens, and I was on that one, and we set the thing up—Dave DeWeese was a strong factor. David—

MULLINS: The chief of ENT.

PAXTON: Yes. He had been the ENT down at Portland Clinic, too. All those guys were in the Portland Clinic; not me. They concocted a plan in which they, in effect, set up a collection agency that was totally outside of the School and not under the control of the School—the UMA—which I didn't mind that. I thought that was perfectly all right. And Bob Stone said he didn't think he'd really care about it one thing or the other. But we did give the School—we gave ten percent to the School and five percent to the department. They concocted that plan.

And I was still seeing patients. After the practice plan began, I never took a patient that I saw in my office out of here, but if I was called to consult on a patient in St. Vincent's or Good Sam, then I would leave the patient in that hospital. Otherwise, I was going to lose a referral source, and I needed it to keep the residency going.

And, of course, what happened was Bob Stone overspent and was spending the money that we gave him and was hiring tenured faculty on that sum of money, which was considered tenuous. So it ended up with pressure from the Board of Higher Education that he gave all the money that we collected from our practice plan to the State, the Board of Higher Education.

Well, that brought down Norma Paulus, because now they expected that, and the State has a right to audit every source of income that they have. So they came down and they were going to audit, and I bucked at that one, but—and they didn't like that anyway, because they didn't want to go over the records after the fact, so we finally agreed that they could audit the gross, and that's the way it's been ever since. I don't think we've had another audit up here, but they came up and audited us.

MULLINS: So this was another one of these transition periods.

PAXTON: Sure.

MULLINS: What were the key components—maybe more important, who were the key players, do you think, in this—making these decisions in this transition?

PAXTON: Well, Dave DeWeese was, and I suppose I was in on it. Bill Krippaehne was very strong.

MULLINS: In favor of having the new system?

PAXTON: Yes. He was a hard worker in getting a practice plan started, too. Clare Peterson was—like Clare always is, he was as much a handicap as he was a help. And who else was involved? Well, certainly not Charles—

PAXTON: What about the orthopedic surgeons?

PAXTON: No. Bill Snell, what he liked to do was sit in his office and go over legal cases, because his father had been, you know, Governor and was killed in an airplane crash. Bill had wanted to be a lawyer, but his father put him through medical school. And it's nice to have a father as governor, because when he finished the residency he was appointed full-time professor.

MULLINS: [Laughs] Was his father alive at the time?

PAXTON: Yes.

MULLINS: His father died in a plane crash?

PAXTON: Yes.

MULLINS: As the Governor?

PAXTON: Yes.

MULLINS: What year was that?

PAXTON: I don't know what year that happened, but he and several of the—the Secretary of State and—I'm not sure about that—high officials were killed in a plane crash. They were from Arlington. I once stopped up there, and I was having lunch, and I said to the guy, "Do you know somebody by the name of Snell?" He said, "Yeah. He owns all the land around here." That was his father, who was a lawyer [laughs].

MULLINS: So who are some of the other key players we were talking about that were in this practice plan here? How about Anesthesiology? Was there a strong anesthesia department?

PAXTON: I was trying to figure out when Fritz Haugen left. Yes. Fritz Haugen had a strong anesthesia department. He was a very capable organizer.

MULLINS: And then Ophthalmology?

PAXTON: Oh, Ophthalmology. Ken Swan was—he was always manipulating and running on—he liked politics, and he was very good at it. You had to watch him very carefully.

MULLINS: Politics medical or politics, state politics?

PAXTON: Medical. The politics of the Medical School. He knew how to manipulate those very well.

Now, let me see, who else did we have? [Pauses.]

MULLINS: How about on the medical side, Dr. Paxton? Were there any participants in all of this? Dr. Hod Lewis?

PAXTON: Hod Lewis did not—he didn't see that much interest in that sort of thing at all and was not there. Adolph Weinzirl didn't, either. Adolph was the first head of Public Health. Public Health, when he came, was under the Microbiology Department. Things have changed all the way along.

It was mostly the surgeons involved.

MULLINS: Because they were the ones who were generating the revenue. This was into the '60s and the '70s.

PAXTON: Yes.

MULLINS: Okay. So, then, what did the President do in terms of providing—he was from '74 to '77, followed by Dr. Jones. Did the President bring together the plan regarding the hospitals?

PAXTON: Well, now, he—once we got a practice plan and we could charge, the thing rolled along pretty well with no problem after that, so he really didn't have much to do with bringing the practice plan together. What he was interested in, as all presidents are, is building. They like to build more and more buildings, and they're very successful at it. And I think I was opposed to appointing a president, and I voted against it. Dr. Lieuallen, of course, rode right over them, but I think appointing—at least in terms of the physical

structure of the School, that having a president around has been remarkable, particularly Peter Kohler.

MULLINS: It's provided the infrastructure to—I think Dr. Kohler has benefited from having a strong presence in the Congress. Would you want to comment on that?

PAXTON: Well, all during the—after the Korean War and up until the 1990s, medical schools—and all the four I've been with have done just as this one has, expand, expand, expand, and it's all been done on government money, or mostly on government money. The research, of course, has been financed by the NIH, but building the actual buildings has been gotten by your favorite congressman and your favorite senator.

MULLINS: Well, it's Senator Morse, right? Did you know Senator Morse?

PAXTON: I didn't know him at all. I appeared before his committee a couple of times.

MULLINS: Do you think he was a friend of University of Oregon Medical School?

PAXTON: I saw no evidence of it.

MULLINS: What about Senator Hatfield?

PAXTON: Well, Senator Hatfield has been a strong proponent of the Medical School since he was governor. He raised \$700 million for buildings around this institution, and written them in as riders on various bills in Congress. What every congressman does. Johns Hopkins has gotten whole wads of it.

Now, it's fallen off since about 1998 because the Congress has run out of money and they're not getting much better, so in the last years charity has played a big part, and the floating of bonds.

MULLINS: Who were some of the memorable individuals that you met, that you'd maybe like to talk about, here at the University, at the Medical School through the years? Who were some of the important characters that influenced—or, individuals that had an influence on the School?

PAXTON: Well, Hod Lewis was greatly respected and an excellent teacher, and everybody liked Hod. Bill Krippaehne was a wonderful Chairman of the Department of Surgery. He'd get you anything. As a matter of fact, when I moved and took over the Neurosurgery department I told him I'd probably want to make a department out of it, and he agreed that would be fine, just let him know. But he was so effective in getting everything I wanted, and I certainly couldn't have matched that with my little—

MULLINS: Why was he so effective?

PAXTON: He was big in the politics. I mean, he was on committees, he did his committee work; he was a hard worker; he took it seriously. He was just a good man for that kind of work.

MULLINS: Did he have contacts at the State Board of Higher Education?

PAXTON: He could talk to them, and he did talk to them. He knew people. I don't know how. Certainly—and with the Legislature.

MULLINS: Through the years did you have to take care of some high-profile patients here at the University?

PAXTON: Yeah, we did.

MULLINS: Would you want to comment, not about the individuals, but about the general principle of having to take care of these high-profile cases or being interrogated by the *Oregonian*?

PAXTON: No, that didn't make any difference one way or the other.

You know, it's very interesting. As I told you, I operated on Charlie Dotter once, and then his friend, Cook, who gave us the interventional thing, came up here and I operated on him for a lumbar disk, and he did fine. And when he went back to Indiana, a few weeks later I got a check for \$15,000 and a note from him saying, "For Christ sake, paint the place, put some blinds on the windows, and get a TV set." And we did, in one room on 12-A. We put a rug on the floor [laughs].

MULLINS: Would you like to comment about the current status of neurosurgery as you look at it over the last fifty years?

PAXTON: Well, neurosurgery has changed so much. It was really an experimental thing. And, besides, most of the earlier neurosurgeons were crazy to go into it. I mean, it was a thing that if you got an infection, for instance, in neurosurgical patients, the mortality was seventy-five to eighty percent. And that I got from Dandy. As a matter of fact, Dandy operated on 390 patients with [unclear] tumors, and only three of them died, and all three of them died of infection. So it's an entirely different business.

Anesthesia is so much better—of course, the CAT scan. It's a whole field. Nowadays—it's changed. Instead of being a diagnostic specialty, as it was in my day, it's now a technical specialty.

MULLINS: Were personalities important in leading neurosurgery during your lifetime? Strong individuals—

PAXTON: Oh, yeah. Well, the generation before me were very hard-driving and opinionated. I think they needed to be. I think they needed to be a little paranoid, or otherwise they wouldn't have done it.

MULLINS: Would you want to comment on the legendary tension between Dr. Cushing and Dr. Dandy?

PAXTON: Oh, there's not much to comment on. Dr. Dandy was a better surgeon than Dr. Cushing, and when Cushing was appointed chief of surgery at the Brigham, they didn't—he insisted that they let him help them design the hospital. So they were behind schedule, as all university hospitals are, and so he, instead of going up and looking at it for a month or so, had to spend a year and a half. When he got back, Dandy had been doing the neurosurgery, and Dandy was better at it.

MULLINS: At Johns Hopkins.

PAXTON: Yes.

MULLINS: So then he stayed there all his career, didn't he?

PAXTON: Yes, stayed all his life.

MULLINS: Are you still in communication with Dandy's son?

PAXTON: Oh, yes.

MULLINS: Where does he live?

PAXTON: He lives in Baltimore. He's in one of the sheltered homes. He's got a peripheral neuropathy that's slowly dragging him down. Mary Ellen, I talked to her, oh, a couple of weeks ago. She lives over in the Northwest district.

MULLINS: That's his daughter.

PAXTON: Yes.

MULLINS: Tell us about your own personal life a little bit. You got married in the '50s?

PAXTON: Yep.

MULLINS: Who did you marry?

PAXTON: Ann Andrews.

MULLINS: Was she one of these nurses that was helping in the operating room, Dr. Paxton?

PAXTON: No, she was a secretary for the CIA on the interrogation unit for the defectors that were coming across. We had a lot of defectors coming across. In the Russian army, if they got attached to a German female and they were caught, their career was over, so what they would do is hotfoot it across the border. And, of course, there was a big interrogation: “What’s your army doing? Where is this going?” She worked at that.

MULLINS: Was she in the military?

PAXTON: No.

MULLINS: But she was in Germany as a secretary for the CIA.

PAXTON: Yeah. Well—

MULLINS: That’s where you met her?

PAXTON: Yeah. There were a lot—because the CIA was expanding so rapidly, they went around to colleges and recruited college kids and they gave them a chance to go overseas. And that’s why she did it.

MULLINS: Were there neurosurgeons practicing in Oregon outside of Portland?

PAXTON: Oh, yes.

MULLINS: Can you tell us a little about that?

PAXTON: There were nine neurosurgeons when I got here in 19—when I got here, Stainsby, who Raaf had trained, was down at Eugene. There was none in Salem; there was a retired naval neurosurgeon down in Medford; and then there was Ed Kloos and Ed Davis and Ken Livingston here, and Ray Grewe and Bruce Kvernland. That was the whole shooting match.

MULLINS: So they would provide neurosurgical services for the entire state, then.

PAXTON: Yes.

MULLINS: People would come here from Salem or Medford or Ontario or places like that to have their neurosurgery.

You did a sabbatical, I think, didn’t you? How many sabbaticals?

PAXTON: I’ve done two.

MULLINS: Tell us about your sabbaticals.

PAXTON: Well, I went to—in '73; I did one year. I went to Kenya and started neurosurgery in Kenya at the Kenyatta National Hospital at the University of Nairobi. I was the only neurosurgeon for seventy-five million people.

MULLINS: The only neurosurgeon?

PAXTON: Well, there was one other one in town, Ruberti. He was Italian, a very typical Italian, too. Bombastic. So I didn't really start it, I was the second one.

MULLINS: But you were working at the university. And what did you do there? How did you start the neurosurgical service for seventy-five million people?

PAXTON: Well, when I got there, they gave me a ward in [Rahimtoola?] that had thirty beds in it and had high ceilings and one light down the center on a wire, and a big desk with all the charts scattered over, and pipes. And they said, "Okay, you start. We'll give you a registrar." So I got a registrar, and we were going like cap busters. We were taking out tuberculomas and hydatid cysts and all—a good 480 cases over that time.

MULLINS: There must have been a lot of trauma.

PAXTON: I didn't take care of the trauma. There was too much. They had six serious injuries a day.

MULLINS: So how did you manage that?

PAXTON: I tried to take care of the head injuries. They would be admitted to the general surgical service. There was only one doctor for every thirty-nine thousand people. There's no way you could take care of everybody, I don't care if you worked twenty-four hours a day. So nobody really worked all that hard. If you can't take care of everybody, why spend a lot of time taking care of just—so we didn't work all that hard.

But the director of the hospital and the chief of Surgery, who's name was [Dahl?]  
—he was an Indian—I was there about three weeks and they decided, whoa, wait a minute. We've got something going here. So they rotated eight of their registrars through my service, and six of them went into neurosurgery, and now they've got twelve or fifteen neurosurgeons in their hospital unit.

MULLINS: How did you end up in Nairobi? Did you pick that out?

PAXTON: No. I was looking around, and I was reading the *New York Times*, and they were saying—there was an ad in there that said, "Wanted, neurosurgeon for the University of"—and it said it was a solo position and would be responsible for starting a neurosurgical service. So I wrote them and said okay. And the next thing I know—then we corresponded—

MULLINS: What did Mrs. Paxton have to say about it?

PAXTON: Oh, she was a travel agent. She would go anywhere.

MULLINS: So you and the children—did your children accompany you?

PAXTON: Oh, sure.

MULLINS: How many kids did you have?

PAXTON: I had three.

MULLINS: So did they go along and live in Nairobi?

PAXTON: Oh, yes, and they went to public schools. It was very interesting. I have a picture of my daughter with her best friends, and it's her and six black kids, and I mean really black. I'm not talking about—and she went to [Kalani?] grade school; she was about nine or ten. And I had a car and the Kenyans didn't, and you'd go there—I'd wheel in and pick her up, and we were sitting there with all those four kids who were going to jam in the back, and I said, "Well, where's my daughter, Kathy?" He said, "Don't worry. You can see her. There's not going to be any problem. She's tall" [laughter]. She was taller than the rest of them.

MULLINS: So they still remember that as a good experience?

PAXTON: Oh, they thought it was the experience of their lives. Kathy still corresponds with some of the people.

MULLINS: So you started a neurosurgical training program.

PAXTON: Yes.

MULLINS: And you were there for a year?

PAXTON: About thirteen months.

MULLINS: Thirteen months; and then when you left, who took over as chief?

PAXTON: They hired an Indian—they hired several—like I said, they hired about two people. They hired an Indian from the All Indian Institute in Delhi, and he was very good. He was very good, a nice guy.

MULLINS: Have you been back?

PAXTON: Yes.

MULLINS: Tell me about that.

PAXTON: Well, I didn't go up to the University. They built a whole new hospital. I was going to go up, and the fellow who was running it, who was trained in the USA, said, "If you'd like to do some neurosurgery, you can come with us." And I thought, "Well, I'm not going to be here that long; the heck with it." I was just going through for a cruise in the Indian Ocean anyway. But we looked around.

Nairobi has changed a lot. It was a beautiful English town; and when we were there the last time, which was about '93, it was all worn out. All the flowers that they had in the roundabouts were gone, and the place was dangerous, because they have so many young men walking the streets, you wouldn't—and the unemployment rate was well over fifty or sixty percent. So if you walked the streets at night, you took a chance of having your—

MULLINS: But there wasn't that sense when you were there as the—

PAXTON: No.

MULLINS: And you were there in the early '70s.

Where did you do your other sabbatical?

PAXTON: I went over at the Army in Landstuhl and set up a head injury unit for them.

MULLINS: What year was that?

PAXTON: That was '82.

MULLINS: You were in the Army still?

PAXTON: Oh, I went back in. They recommissioned me.

MULLINS: Oh, they did? And your rank was?

PAXTON: Bird colonel.

MULLINS: Oh, O-6.

PAXTON: And that was kind of fun. I went over, and Hewlett-Packard sent over a whole bunch of monitoring equipment for intracranial pressure, and you could push the button and it would come out, chart it in the week, and all sorts of things. But then, when I got all that equipment in there, they sent three engineers to fix it.

And we did very well. They were not very satisfied with their previous neurosurgeon, but, anyway, they gave me a commendation medal when I left, and I thought that was pretty nice.

MULLINS: And Mrs. Paxton went with you?

PAXTON: Yes.

MULLINS: The children were all grown up by that time?

PAXTON: Well, the youngest daughter we sent to the University of Maryland branch. She had a ball there.

MULLINS: So what do you think of the role of a sabbatical in an academic life? These aren't what I'd call hard-charging. You're not doing research somewhere.

PAXTON: Well, I think you're making a mistake not taking a sabbatical, because it gives you an opportunity to stand back and look at yourself and to review what you've done and to make amends. And if you want to study something, that's fine. And it gives you a chance to be of service to the world, if you want to be that way.

MULLINS: Did they pay you when you were in Kenya?

PAXTON: Oh, sure.

MULLINS: The Kenyans paid you.

PAXTON: Yes.

MULLINS: Oregon just sort of gave you a—you didn't get an Oregon salary.

PAXTON: Sure. You got a half salary.

MULLINS: Okay.

You've seen the evolution of academic surgery over fifty years. Do you think it's changed for the worse, the better, or is it really—?

PAXTON: Well, the thing about medicine is, it's so improved that you can hardly say anything is worse than it used to be, because the techniques and the science and such. I think it would have been a lot better if the State or the Medical School could pay all of your expenses and pay you a decent salary so you don't have to go out and beat the bush for it.

MULLINS: I think you remember a day when the patients really had very little choice in what happened to them. There's been a big change in that regard. Do you have any comments about—?

PAXTON: Oh, I think that's for the better, because we—I have to admit that when I had the clinic, ran the clinic on the outpatients—and, by the way, there were very few administrators around here. This whole institution, when the new hospital opened, was run by Baird, Holman, Jarvis Gould in the County, Gwynn Bryce on the Outpatient Clinic, Caroline Pommarane ran the student evaluation, and Dick Sleeter. That's about all the administration they had. They've got more people than that in the President's Office now.

But anyway, we didn't treat the patients very well. In the clinic I had for neurosurgery, all the patients had to come in at one o'clock, and then they'd sit there until I got around to seeing them. They wouldn't make appointments.

MULLINS: The School administratively just couldn't figure out how to do it?

PAXTON: Well, either that or they didn't want to. I never knew that. And I didn't have the secretarial support, anyway.

MULLINS: Did you do a lot of night surgery when you were younger?

PAXTON: Oh, boy. You always did.

MULLINS: How about when you got older? Did the residents take care of most of that?

PAXTON: Well, the way I—the chief resident took care of the trauma. If he had any trouble, he called me in. I don't know as they—they only had trouble once, as far as I know. But the reason that they go in now is because it's required by Medicare.

MULLINS: Yeah. That's a change.

PAXTON: That's forced some tremendous changes in the method of practice.

MULLINS: Do you want to comment on the eighty-hour limitation in hours a week that residents now are subjected to?

PAXTON: Well, I don't know as I—on the first internship I had I was on twenty-four hours a day and 365 days a year, and I don't remember I ever got all that tired, including one night when I had nineteen admissions, and I finished the last one at seven a.m. in the morning. I'll never forget that one. I remember the history and physical I wrote. The chief complaint: big ears. Findings: big ears [laughter]. Recommendation: move his ears back.

MULLINS: Well, we were talking about who the people you think have made a favorable influence on OHSU, or the University of Oregon at that time, in the span of your career. Who do you think you would want to remind us were people who made a big difference?

PAXTON: Medical difference or in the structure of the Medical School, because I think—

MULLINS: Well, let's start with the medical difference.

PAXTON: On the medical thing, certainly Charlie Dotter put us on the map. Now, Charlie—I heard what's his name, Keller?—say that Charlie had been nominated for the Nobel Prize at one point. He didn't get it. He probably didn't live long enough. He certainly deserves it. He has changed medicine, there's no ifs, ands, or buts about it.

Al Starr has changed medicine. His valve was the first really successful valve to be used.

Let's see, who else do we have? [Pauses.]

MULLINS: Well, let me ask you about those two individuals. Those are two individuals that implemented a new technology.

PAXTON: Right.

MULLINS: They must have some complications and problems when they started out. How did they deal with their—how do people—you've seen it in neurosurgery as well. How do people deal with the struggle of a new development?

PAXTON: Well, it usually doesn't bother them, you know. They are usually completely devoted to the idea; they're convinced it's going to work. I remember when I used to see Al's patients, first at St. Vincent's, they were having a ten percent mortality on those valves; and they were having a fair number of complications from the pumps because they were primitive and they were sludging blood and a bunch of other things. But he kept right on; it didn't bother him one way or the other. I don't think it made any—

MULLINS: So he had confidence that it was going to pay off in the long run.

Have you seen a similar thing in neurosurgery? Of course, you could say you did with the sympathectomies and the thalamotomies.

PAXTON: Well, they're back doing thalamotomies now, and they're working very well, in select patients. You can't do it with anybody.

MULLINS: Do you think it's harder to be that kind of an innovative surgeon in the current environment, IRBs, oversight?

PAXTON: Oh, sure. Gosh, we practiced hypophysectomies before we started doing them on the cadavers. Nowadays, if you got sued, you couldn't win a case because you said you never trained for the darn thing. But that's not true. Once you learn and get the hang of

doing the surgery, usually you can do damn near anything that you thought about and studied about.

MULLINS: Now, you were going to talk about the administrative leaders in your lifetime here at OHSU who made a difference in the Medical School. Who would you want to point out that you think gets credit for having made things better?

PAXTON: Well, I think the presidents have. Certainly, Laster becoming acquainted with Hatfield has done tremendous things for us. I think Peter Kohler is changing the whole—and I think his move to move down to the Macadam area, if it pans out, is going to change the School a tremendous amount.

Let's see, who else? Certainly, Dave Baird was.

MULLINS: Could you talk a little bit about Dr. Baird, because many of us don't really know him or recall him. You said earlier that he had a skill of communicating with the Legislature.

PAXTON: Oh, yes. He was from eastern Oregon; he knew a lot of those conservative people down there. He liked to go down and have a couple of drinks with them and play poker. So he was an old buddy, and he cultivated that image.

MULLINS: Was he good to you?

PAXTON: Oh, yes.

MULLINS: Encouraging or—?

PAXTON: Well, he didn't encourage, but he'd just give you support. For instance—it was always kind of interesting. You'd go in and ask for something, if you'd go in and say you need ten thousand dollars: "No, absolutely not." And you'd go out and you'd come back about four or five days later and said, "I've raised two thousand." "Oh," he said, "I'll help you" [laughter].

[End of Tape 2, Side 1/Begin Tape 2, Side 2]

MULLINS: So you knew he was an ally, he wasn't some—

PAXTON: Oh, no. He was a great ally for the school. He really supported the faculty.

MULLINS: Was he on the "enemies list" of some of the people downtown that didn't like to see the University do well?

PAXTON: You bet. Well, you know, they weren't really enemies of the School, so much. They wanted to make sure that—hoped that the School would be controlled by

somebody, like the Portland Clinic did before then. That way, it gave them a real advantage. And, of course, it didn't work out that way. The School is now the dominant force in the state.

MULLINS: Can we talk a little bit about the current problem of medical-legal tension? Do you think the situation is a threat to medicine in terms of lawsuits?

PAXTON: Oh, sure, it is.

MULLINS: Can you just elaborate on that a little bit? What have you seen happen in your lifetime?

PAXTON: Well, you know, even the cases won in court, in the studies that I've seen, half of them are not malpractice, because it depends so much upon opinions. And it's very difficult to judge that sort thing, because you shouldn't judge a man unless you've been in his shoes, and, of course, you aren't. And in any situation, if things go wrong, and in about ten percent—or a sizeable percent of them are going to go wrong, you can always point to someone and say he's negligent.

MULLINS: But why do you think neurosurgeons have taken the biggest increase in their premiums? They seem to be a primary target for lawsuits.

PAXTON: Well, the neurosurgeons actually are not having more lawsuits than they had. They've always had a fairly low number. The awards are so high. If you get someone who can't talk and is paralyzed on the right hand side, he might come out with \$25 million. You can become wealthy. But it's the size of awards that's really killing the malpractice rates.

MULLINS: Is there a response that we should muster to try and change—?

PAXTON: Well, the one they're doing now is they're trying to limit how much you can win for pain and suffering. And, of course, they had that as a law, and it did reduce the malpractice premiums a lot, but the Supreme Court overruled it.

MULLINS: What do you think about this concept of full disclosure of all complications right immediately to the patient?

PAXTON: That's going to—now, that's been tried. Over in Vancouver, if something went wrong, they decided that they were going to tell the patient, and it would go just fine. Well, what that amounted to is they just had—everybody they told, they got a suit out of it, so they dropped it. I don't think full disclosure is going to do anything but get you into real trouble.

MULLINS: How about preoperative informed consent? Have you seen a lot of change in that in your lifetime?

PAXTON: No—well, not for me. It has for a lot of other people, because we were very paternalistic when we started. You know, “Don’t tell Mother that she’s got cancer, because she’s so nervous it’ll drop her dead.” This was true all over. “Well, don’t tell them it’s multiple sclerosis, because it’ll ruin them.” But I had a couple of patients, one with multiple sclerosis and the second with carcinoma of the prostate, that I let the wives—one husband and one wife talk me out of telling them what it really was. I called the multiple sclerosis a little neuritis. And both patients came back within short order and came up and said, “You made a mistake. I’ve got multiple sclerosis. My doctor found it.” And I said, “That’s it, boy.” I’m known as the black paperhanger. I told them the worst that could happen.

MULLINS: Which does lead us to one of the things I wanted to talk about. You were the professor of neurosurgery in the State of Oregon. Did you feel like you were the bottom line, for some of these more difficult cases, for opinions?

PAXTON: Yes. I got—a lot of the patients that were sent to me were sent to me by neurosurgeons who—they thought they didn’t want to handle the problem.

MULLINS: Did they send you their complications?

PAXTON: Yes.

MULLINS: How did you manage that?

PAXTON: Well, I’d just treat it like it was any other disorder and did the best I could with it.

MULLINS: When the patient asked, “Did my doctor make a mistake?” how would you manage that? I don’t mean to put you on the spot here, but...

PAXTON: Well, I don’t think—

MULLINS: I’d like to know a little bit more about the job of being the chief of Neurosurgery in a field that’s pretty tough and you’re the bottom line. And you did it for a long time, doctor.

PAXTON: But I never told them anybody made a mistake. I explained what was wrong and let them come to any conclusion they wanted to.

MULLINS: I think Dr. Krippaehne had a similar kind of practice.

PAXTON: Oh, he had a bad practice. I remember him struggling in the operating room with pieces of intestine that someone had not been able to get back together, and he was trying to figure it out, and I used to think, “What a miserable practice he’s got.” And he was good at it.

MULLINS: Well, I'm sure you were good at taking care of tough neurosurgical problems.

PAXTON: Oh, I think you're right. There's no question about it [laughter].

MULLINS: I think one of the toughest things I remember were the children with the shunts. They were constantly having to be revived.

PAXTON: All shunts plug. But, you know, when Joe Piatt came here, he decided to analyze what we had done. He went over it, and he was, I think, surprised because he came in and said, "It's really amazing. Your record matches anybody else in the world." And he said, "You've done very well." And what I didn't tell him is ninety percent of those shunts were done by the residents.

MULLINS: So Joe Piatt was one of the junior—

PAXTON: Pediatric neurosurgeon.

MULLINS: Pediatric neurosurgeons.

PAXTON: And a very good man.

MULLINS: Did you hire him?

PAXTON: No.

MULLINS: He was hired after Dr. Burchiel took over.

PAXTON: Yes. Burchiel hired him. Burchiel knew him because Burchiel was in Seattle and Piatt was on active duty at whatever the fort is up there.

MULLINS: It does raise the point, Dr. Paxton, that you're right: nine out of ten of the shunts were done by the residents, but one out of ten that's really tough, Dr. Gallo or Dr. Paxton made sure it got done.

PAXTON: Well the tough—well, you know, I had these three people that were in their late twenties that I'd done twenty or more shunts on, and when they plugged, they'd have one pupil dilated, and it had to be done right now, no ifs, ands, or buts. During the course for the next—they all three died with acute hydrocephalus and shunt failure.

MULLINS: So we were going to talk more, I hope, about the litigation thing. How do you see that working out? Is it going to resolve?

PAXTON: It's not going to resolve unless they—the trial lawyers put too much money into the politics. They are the big contributors, and the educators. Unless they pass

the laws and the laws are going to restrict what you can get, then I don't think—it's going to keep right on like the way it is now.

MULLINS: Yeah, I don't see it changing, either.

Well, I'm coming to a close here. I guess—could you just comment on, again, your overview of neurosurgery in your lifetime? Has it been a good career for you?

PAXTON: I think it's been a great career for me. It's a little harder—in retrospect, it was harder than—nowadays, I don't know as I'd go into it. I would pick something a little easier. The other thing is, and it's also very nice about retirement, is I don't have to make life and death decisions, and that's a relief.

MULLINS: You worked a lot of hard hours taking care of bad problems, I would assume.

PAXTON: Yes. We worked twenty-four hours a day. When John Raaf and I were in practice, it was not unusual to see both of us down at the emergency room, seeing a patient. We didn't take weekends—in fact, we didn't start taking weekends off until Mike Mason refused to join the group unless we rotated weekends. And we looked at each other and said, “What have we been doing all these years? We must be crazy” [laughs].

MULLINS: Well, do you have any final comments that you would like to make, Dr. Paxton?

PAXTON: No. I just hope you audit this [laughter].

MULLINS: Well, thank you very much for your candor, sir, and giving us this perspective.

[Quiet discussion; video producer Matt Simek providing additional questions to interviewer.]

MULLINS: Okay. Dr. Paxton, we were talking about the doctor-patient relationship, and we talked about it in the context of informed consent, the emphasis on that today versus the paternalistic “Mr. Jones, this is what's going to happen.” Are there other key changes in the doctor-patient relationship that you've seen evolve or change in your professional career?

PAXTON: Well, the patients have gotten a lot better educated, and so they ask a lot of questions that they didn't used to ask, and they don't mind doing it, and they don't mind embarrassing their doctor if they think that that's wrong, one way or the other. I think that's for the better, in the end, because I think the patient is the name of the game. He's the guy we ought to protect, and I think you ought to give him all the information you can, one way or the other. It may make your ears a little red, but that's not a permanent change that I know about. So I think they're getting better, seen from my point of view. A little more difficult, perhaps a lot more difficult than it used to be.

MULLINS: Are you concerned about the influence insurance companies are having?

PAXTON: Oh, yes. I think that's terrible. I don't think the insurance companies ought to decide which patient goes—when you go into the hospital or when you don't, or whether or not you can do an operation.

MULLINS: Or who should do your operation?

PAXTON: Or who should do your operation.

MULLINS: Do you think they should have panels of neurosurgeons who should only be allowed to do certain procedures?

PAXTON: Well, you know, they got rid of that, for years gone by. Yes, they can do that. The insurance company used to hire them. As a matter of fact, one of the first lawsuits against an insurance company was here in Oregon because the first health insurance policy originated in Oregon. But I think they have too much sway in the name of money.

MULLINS: What about the issue that patients' expectations are very high?

PAXTON: They're much too high. I mean, the advertisements, you know, the newspapers, all of these breakthroughs—and they think they're all going to be cured immediately.

MULLINS: You're in a specialty which certainly has its bad outcomes. How did you manage that through the years? First of all, were you pretty candid with the patients?

PAXTON: You bet. I wasn't—

MULLINS: "It's a brain tumor and you're not going to survive;" that kind of thing?

PAXTON: Well, I would tell him, "You've got a brain tumor," and if it looked bad, I'd tell him, "It looks very bad, and the chances are that what we can do for it is not very much, but we'll do the best we can."

MULLINS: And did patients seem to understand that more previously than they do now? I know you don't practice—

PAXTON: I don't know now. I haven't been at it in ten years. From what I read about it, they get upset if they don't get the kind of result they expected, and they're apt to resort to the legal approach to the problem.

MULLINS: Okay.

Is that it?

SIMEK: Do you have a high point in your career?

PAXTON: No.

SIMEK: How about a low point?

PAXTON: Not really. I think I'm pretty level headed and not too easily upset. I'm a cyclothymic. I didn't swing from depression to elation. That was not my style.

MULLINS: Well, you've known some very successful prominent neurosurgeons. Do you think they had good careers? Do you think Dr. Dandy had a good career?

PAXTON: Yes, Dr. Dandy did. He was—and that's all he did. You know, he had a coronary, and they told him—well, in those days—“Stay in the hospital,” and four days later he was out of the hospital. Then he goes back to operating immediately, and six weeks later had a fatal one.

MULLINS: But he loved to operate.

PAXTON: Oh yeah.

MULLINS: He did good work and he got good results, for the most part?

PAXTON: Yep.

MULLINS: How about Dr. Schwartz? You said he worked pretty hard his whole lifetime.

PAXTON: I think he was pleased with the way his life worked out.

MULLINS: Would you want to comment on Dr. Raaf?

PAXTON: I think John was very unhappy after he retired. But John was a very hard worker.

MULLINS: So from '36 until what year, about?

PAXTON: Well, when did he retire? He was seventy-four when he quit. He was seventy-two when he had an aneurysm down at Good Sam, and he asked me to go down and do it because he said he was afraid if anything went wrong and they got sued, well, the hospital would throw him off the staff.

The hospital was—before the law about practicing as long as you want in age, they would stop people from operating at seventy. I remember John Hand, who was a general surgeon that was up at St. Vincent. He came in—they called him in, and they said, “Dr.

Hand, we think you ought to quit.” And John said, “Thank you very much. I’m glad to do it, that’s exactly what I’ll do.” And he did. But they don’t do that anymore.

I’ve thought that surgeons should retire at age sixty-five. And I recognize that there are many who could operate longer than that—perhaps not as long as Dr. DeBakey—but there are plenty of them that should have retired before sixty-five. So I still think that’s about the right spot.

MULLINS: Any other questions?

SIMEK: Would you just like to take a moment to talk about where you see the future of medicine, where you think it might be in fifty years?

PAXTON: I don’t know about fifty years, but I know there’s going to be a shortage of doctors coming up in, I think, all fields, because there are too many of them leaving it. I don’t see—the medical schools are increasing, but they’re not increasing as fast as the population is. After all, we’re growing by about two-and-a-half million people a year. That’s a barrel of doctors. I think there’s going to be a time when it’s going to be difficult to find a doctor.

MULLINS: One of the solutions is to turn out more neurosurgeons. Do you think there are too few neurosurgeons?

PAXTON: Yes. Well, I’m not sure about that. There’s going to be. There are certainly less than there used to be, but I—

MULLINS: Was there a limit put on the number of neurosurgeons by the neurosurgery leadership?

PAXTON: No. They did, in effect. For a number of years they didn’t approve any—they went for maybe ten or fifteen years that they did not increase the number of residencies, but they have in the last few years been doing it.

MULLINS: So there’ll be plenty of neurosurgeons to handle the problems.

PAXTON: I don’t think so. I think there’s going to be—there’s a shortage of neurosurgeons now, I think, but I don’t know that for sure.

MULLINS: What’s worse, Dr. Paxton, after working hard all your life, you tell us that maybe in retrospect you shouldn’t have worked so hard [laughter]. So I think the new generation has figured that out prospectively.

PAXTON: They don’t do things the way that we did in 1950 and ‘51.

MULLINS: That's partly the eighty-hour workweek. I think that they're also interested in lifestyle. I think there's more interest in specialization, the sort of thing we were talking about.

PAXTON: Yeah. Well, the number of specialties has just increased astronomically. We're getting almost to the point, like the British have had, where some guy will just go in to doing liver disease, period.

MULLINS: I think that's probably going to happen in neurosurgery as well.

PAXTON: Oh, yeah. It's already happening. But that means that there's no such thing, really, effectively, as a solo practitioner. You've got to practice with a group because you need so many specialists. That's going to change all of medicine. I think you're probably going to end up with big clinics. Very few neurosurgeons now practice alone.

SIMEK: Is that complexity and that specialization contributing to the education problem in that it takes longer to turn out a doctor?

PAXTON: Oh, yes. Well, now, when you finish medical school, you literally aren't a doctor yet. The average person spends at least three years in postgraduate training, and in neurosurgery, now, here, it's seven. Then they turn out a general neurosurgeon. You've got to go on another year or two in order to be a specialist. That takes a lot of your life.

When I started with a general surgeon—that's why Raaf and W.K. Livingston—because he did some neurosurgery. Hip fractures, they were all done by general surgeons. One of the first cases as an intern I ever helped on was—they were putting a Lorenzo[?] screw in a fractured neck of the femur. And it was being done by a general surgeon.

MULLINS: Excellent operation.

PAXTON: It worked well [laughs].

MULLINS: Okay. Well, thanks a lot. It was great.

PAXTON: Alright.

SIMEK: Thank you, doctor.

[End of interview]

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